



OUTPATIENT DIAGNOSTIC CENTER RENEWAL APPLICATION

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at <http://tennessee.gov/health/topic/hcf-professionals>. Please check this website periodically for updates.

Name of the Facility/Agency _____

Facility License Number _____

Location of the Facility:

Street _____ City _____

County _____ State _____ Zip _____

Phone Number (____) _____ Fax Number (____) _____

Twenty-four (24) Hour Emergency Phone Number (____) _____

E-Mail Address _____

Administrator _____

Mailing address if different from the Facility location address:

Name _____

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

Division of Health Licensure and Regulations, Office of Health Care Facilities, 665 Mainstream Drive, Second Floor, Nashville, TN 37228-1254

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:
_____ Individual _____ Partnership _____ Corporation _____ Limited Liability Company
_____ Church Related _____ Government/County _____ Other

b. Check One: _____ For Profit _____ Non-profit

c. Legal Entity checked in 1.a:

Name _____ Phone Number (_____) _____

Street _____

City _____ State _____ Zip _____

d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

Name _____ Address _____ City, State, Zip _____

Name _____ Address _____ City, State, Zip _____

Name _____ Address _____ City, State, Zip _____

(If additional space is needed, please use a separate sheet)

2. a. Is your facility/organization accredited by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? Yes _____ No _____ Expiration Date _____

b. Is your facility/organization deemed by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? Yes _____ No _____ Expiration Date _____

3. a. Is this facility chain affiliated? Yes _____ No _____

b. If yes, list name, address and phone number of the parent company.

Name _____ Phone Number (_____) _____

Street _____

City _____ State _____ Zip _____

4. a. If a corporation, is there a holding company/parent corporation? Yes _____ No _____

b. If yes, list the name, address and phone number of the holding company/parent corporation.

Name _____ Phone Number (_____) _____

Street _____

City _____ State _____ Zip _____

5. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? Yes _____ No _____

If yes, list names and addresses of all such facilities:

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